SOUTH CAROLINA DEPARTMENT OF
Disabilities and Special Needs

Transition Services/ ID/RD Division
3440 Harden Street Ext. PO Box 4706
Columbia, SC 29240

********** Individual Contact Information**********

Individual's Name: _____ Date of Birth: _____

Legal Guardian/Caregiver (if applicable): _____

Street Address: _____

City and Zip: _____ County: _____

Phone for Individual: _____ E-Mail Address: _____

School District/ School and Teacher Name (if applicable) _____ In School _____ Out of School

_____

DDSN agency or provider name and case manager (if applicable)

_____

********** Release Information **********

In an effort to increase communication and effective transition planning for the above named individual, permission is granted for the sharing of confidential information, including but not limited to, information regarding disability and eligibility, goals, and services provided by below designated agencies. I understand that this information is necessary for transition planning and coordination by the below listed agencies. I understand that this information will be held strictly confidential and is protected under state and federal laws, furthermore this information cannot be released by the recipient or other parties without my written consent unless otherwise provided for in the law and regulations. I also understand that this release will remain in effect until I revoke my consent. I may revoke this consent at any time. The below signature indicates a consent for the release and exchange of confidential information (as follows: testing/ psychoeducational evaluations/ medical information regarding disability, Individual Education Plans (IEP), Individual Plans for Employment (IPE) and/or Individual Plan of Supports for Employment (IPSE), and information about eligibility and services) and other information as deemed necessary for transition planning between the indicated agencies:

I agree to the sharing of this information across the following agencies (CHECK ALL THAT APPLY):

_____ South Carolina Department of Disabilities and Special Needs; DDSN service providers, case managers and University of South Carolina Center for Disability Resource Center staff.

_____ Local school district teachers/staff (Please list School District here: _____)

_____ South Carolina Vocational Rehabilitation Department and/or Commission for the Blind

_____ ABLE-SC, Accessibilities, Walton Options

_____ Other agencies as indicated: _____

Individual Signature: _____ Date: _____

Legal Guardian (If applicable): _____

Revised 10-2017